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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Mar/23/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: work hardening x 10 sessions

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., Board Certified Physical Medicine and Rehabilitation and Pain Medicine

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. It is the opinion of the reviewer that the request for work hardening x 10 sessions is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is xx/xx/xx. On this date he was replacing xx when a large xx struck a pipe in the ceiling causing a sudden, sharp and unexpected jolt to his right shoulder. MRI of the right shoulder dated 09/10/14 revealed a complete tear of the rotator cuff. The patient completed an initial course of physical therapy and subsequently underwent right shoulder acromioplasty and decompression and excision of acromioclavicular joint on 10/24/14. The patient completed 24 postoperative physical therapy visits with moderate improvement. Follow up note dated 01/14/15 indicates that there is tenderness to palpation of the AC joint and acromion. Right shoulder range of motion is decreased. Pain was elicited on motion. Shoulder weakness was observed. Functional capacity evaluation dated 01/21/15 indicates that the patient's required PDL is medium-heavy and current PDL is light-medium. Assessment dated 02/02/15 indicates that diagnosis is psychological factors interfering with recovery to a general medical condition, rule out pain disorder associated with both psychological factors and a general medical condition, chronic. Psychosocial evaluation dated 02/02/15 indicates that BDI is 6 and BAI is 2. Current medication is Tramadol.

Initial request for work hardening x 10 sessions was non-certified on 02/06/15 noting that there is no employer-verified return to work PDL. There is no documentation of a job to return to. There is no employer documentation that progressive return to work is not possible. There are no documented results of psychometric testing. The denial was upheld on appeal dated 02/19/15 noting that the physician's note dated 01/13/15 states, "while improved, progress with treatment-rehab has not plateaued". The records provided indicate the claimant has completed 20 sessions of postoperative PT. The ODG guidelines for postsurgical PT of complete ruptured rotator cuff tendons is 40 sessions of PT.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient is noted to be status post right shoulder acromioplasty and decompression and excision of acromioclavicular joint on 10/24/14 and has completed 24 postoperative physical therapy visits. The submitted records fail to establish that the patient has plateaued in therapy. The Official Disability Guidelines would support up to 40 postoperative physical therapy visits for the patient's diagnosis. The Official Disability Guidelines require documentation of treatment with an adequate course of physical therapy with improvement followed by plateau. The submitted psychosocial evaluation fails to document a significant psychological component to the patient's condition that would require a multidisciplinary program. There is no indication that the patient has undergone psychometric testing with validity measures to assess the validity of his subjective complaints. As such, it is the opinion of the reviewer that the request for work hardening x 10 sessions is not recommended as medically necessary and the prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)